



First Steps Provider Billing Manual

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Revision History

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Section 1: Introduction

Overview

Indiana Family and Social Services Administration (IFSSA) implemented the Central Reimbursement Office (CRO), statewide, on August 1, 1997. Electronic Data Systems (EDS), performs the administration of the CRO. In 1995, EDS implemented the Indiana Advanced Information Management (IndianaAIM) system, a state of the art system which is capable of processing claims for other programs with the State of Indiana. IndianaAIM is the financial system for payment of all early intervention services. EDS is located at:

**950 North Meridian Street, Suite 1100
Indianapolis, Indiana 46204**

EDS provides a solution developed after many sessions with First Steps, Division of Technical Services (DTS), and EDS. First Steps and DTS provide a clear understanding of the program's needs, including finding a new contractor that can do the following:

- Maintain and exceed current level of service
- Dedicate itself to excellent provider service
- Not disrupt service
- Develop a new Web-based technical solution without increasing cost
- Upgrade current system point of entry (SPOE) software
- Make provider payments accurately and in a timely manner

Central Reimbursement Office

The EDS design includes paying all providers from an interim funding source based on submission of claims. The CRO then seeks reimbursement from an appropriate payment source. This includes billing private insurance, Children's Special Health Care Services, Medicaid and Temporary Assistance for Needy Families (TANF)/TANFmaintenance of effort (MOE)for eligible and enrolled children, and others.

First Steps

First Steps is administered by the Bureau of Child Development (BCD) within the IFSSA. First Steps brings together families and professionals from education, health, and social services agencies. By coordinating the locally available services, First Steps is working to give Indiana children and their families the widest array of possible early intervention resources.

Indiana is committed to a family-centered, community-based system of early intervention services for eligible infants and toddlers and their families. As part of that commitment, the CRO was designed to support family choice regarding who will provide services and where those services will be provided. Indiana entered Part C entitlement during fiscal year 1995 and has been working diligently to access numerous funding sources identified for early intervention services.

Section 2: First Steps Provider Enrollment

Overview

To participate in the First Steps program providers must be enrolled with the EDS Provider Enrollment unit. Provider enrollment information and the required forms are accessible on the First Steps Web site at <https://www.infirststeps.com>. Provider Enrollment forms must be mailed to:

EDS-Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

Note: Providers should not send forms by certified mail, delivery service, or hand delivery. Using these methods does not speed processing. All forms follow the same handling process regardless of how they arrive at EDS.

Once EDS Provider Enrollment has received all of the completed forms from the provider requested on the checklist, the enrollment forms are reviewed to ensure proper enrollment requirements have been met. The enrollment requirements are delineated in the *Early Intervention Personnel Guide* and the provider enrollment application instructions. These documents can be found on the First Steps Web site <http://www.infirststeps.com>.

Note: Electronic funds transfer (EFT) – Direct deposit is a mandatory enrollment requirement. The EFT form can be found in the provider enrollment application and as an individual form on the Web site <http://www.infirststeps.com>.

If the enrollment requirements are met, the provider is enrolled and assigned a provider identification number(s) based on how the provider has selected to enroll.

- If a provider is enrolling as a individual billing provider, one provider identification number is issued for billing and one for rendering services.
- If a provider enrolls as group provider with rendering providers, one provider identification number is issued for the billing entity and individual rendering provider identification numbers for each servicing provider.

These provider identification numbers are used to enroll in the Web interChange which provides access to view prior authorizations (PAs), view provider profile information, and the claim billing process. A confirmation letter is sent to the provider with the provider identification number(s), information regarding the First Steps program, and the provider profile information for verification.

Providers are also required to credential with the First Steps program after their enrollment. The confirmation enrollment letter supplies the required date to obtain the credential. Additional letters are sent to notify the provider of the upcoming credentialing date. If the provider has not responded, a final notice is sent to the provider terminating participation in First Steps. Once the provider has met the credential, an approval letter is sent to the provider along with a certificate. Credentialing requirements are provided in the *Early Intervention Personnel Guide* which can be found on the First Steps Web Site at <http://www.infirststeps.com>

If the documentation is not complete, the enrollment forms are returned to the the provider (RTP) with a letter from EDS explaining which part of the application is missing. To complete the application process the provider must resubmit the enrollment forms.

All forms are completed within 10 business days of receipt. For questions regarding the status of provider forms or to learn about the processes, contact the Provider Enrollment Customer Service Line at 1-877-707-5750.

First Steps Provider Enrollment Forms on the Web

Documents and forms needed to enroll, credential, recredential, or to update provider information as a First Steps provider are available on the First Steps Web site at <http://www.infirststeps.com>. The forms are in a Adobe pdf format for providers to download and print. The First Steps Web site also includes additional links to policy information and contact information for EDS.

On the First Steps Web site at <http://www.infirststeps.com>, placing the cursor on the Service Matrix portion of the window displays the Service Matrix Menu.. Select the link for **Provider Enrollment** as shown in Figure 2.1.



Figure 2.1 – Provider Enrollment Window for Indiana First Steps Program

Section 3: Service Authorization

Overview

There are timelines in place to insure that providers receive prior authorizations (PAs) from the EDS Central Reimbursement Office (CRO) in a timely manner. The CRO issues the PAs based on the information entered at the system point of entry (SPOE).

The child is required to be in intake status and assigned an intake coordinator. Intake status indicates that no Individualized family service plans (IFSPs) have been developed and the process is in place to establish the child's initial eligibility.

1. Once assessment is complete the provider completes the *Evaluation Report* form and faxes it to the intake coordinator within two business days of completing the assessment. The intake coordinator enters the PA at the SPOE based on the information on the *Evaluation Report* form. The intake coordinator enters the information from the *Evaluation Report* form within two business days of receiving it. The information is processed at the SPOE on a daily basis and sent to EDS/CRO for processing.
2. If the child qualifies for First Steps an initial IFSP is developed with the family and the appropriate provider(s). PAs for providers who attend the IFSP are entered, based on the amount of face-to-face time the provider spends in the meeting, which is rounded down to the nearest 15-minute increment. Intake coordinators enter this information within two business days of the IFSP meeting. The information is processed at the SPOE on a daily basis and sent to EDS/CRO for processing.
3. On-going services are entered based on the *Services* page of the IFSP. The authorization effective date will be the later of the parent's signature or the physician's signature date. The intake coordinator enters the on-going services within two business days of completion of the IFSP. The information is processed at the SPOE on a daily basis and sent to EDS/CRO for processing.
4. In all cases, providers should allow five to seven days from the time the authorizations are entered to view PAs on the EDS Web interChange system.
5. If the authorization is not on Web interChange, the provider must fax all pertinent information to the SPOE office and request that the SPOE ensure that the PA is entered. If the PA has been entered, the SPOE should *re-batch* the child and inform the provider that the PA has been entered and re-sent to EDS/CRO.
6. The SPOE does not check authorizations or provide authorization numbers over the telephone.
7. In order to increase, change, or decrease on-going services after an IFSP is completed there are several steps that must be accomplished including the following:
 - The provider requesting the change must document the reason(s) for the change and provide this information to the service coordinator.
 - The service coordinator contacts the other team members, including the family of the child, to determine if they are in agreement with the change.
 - The service coordinator completes an IFSP *Change* page and submits it to the child's primary care physician for signature. The parent, the primary care physician, and the service coordinator must sign the *Change* page before it can be entered into the SPOE computer system for submission to the EDS/CRO.

- The start date of the service cannot be prior to the latest signature on the *Change* page. For example, if the doctor is the last signature received the service can begin on the day the doctor signs the page.
- The service coordinator must mail or fax a copy of the completed *Change* page to the provider and send a clean copy or the original form to the SPOE for data entry.
- Providers should begin services with the family as soon as they receive a copy of the completed *Change* page. They should not wait to see the PAs on Web interChange.
- The SPOE does not accept faxed data entry.
- The service coordinator has five business days to get the *Change* page to the SPOE.
- The SPOE has two to five business days to enter the information on the *Change* page.
 - If the *Change* page is incomplete the SPOE returns it to the service coordinator with the *Missing Data Entry* form for correction. This delays the process.
 - In all cases providers should allow five to seven days from the time the PAs are entered to check Web inter Change.
 - If the authorization is not on Web interChange, the provider must fax all pertinent information to the SPOE office and request that the SPOE ensure that the PA is entered. If the PA has been entered, then the SPOE should *re-batch* the child and inform the provider that the PA has been entered and re-sent to EDS/CRO.
 - It is the responsibility of the provider, and not the service coordinator, to follow up on missing authorizations.
 - The SPOE does not check authorizations or provide authorization numbers over the telephone.

The same processes are essentially used for annual IFSPs. Annual IFSPs must be completed prior to the expiration of the existing IFSP, but the services written on the new IFSP do not end until the existing IFSP expires.

No faxed information for data entry or for filing in the Early Intervention record is accepted. All data entry and filing must either be mailed or delivered to the SPOE. Faxed data entry or filing is not processed. Only requests for authorization numbers from previously submitted documentation may be faxed.

Questions concerning authorizations may be faxed to the SPOE, but original data entry is not entered if it is not received either by mail or delivery. **There are no exceptions.**

System Point of Entry (SPOE)

Service authorizations are initiated through the SPOE based on receipt of a source document. The system relies on prompt receipt of source documents from service coordinators.

These sources include an IFSP, a request for an authorization for assessment/evaluation or IFSP development, or an IFSP *Change* page.

Upon receipt of a source document, the SPOE promptly enters the information into an electronic system that captures sufficient information to create authorizations for services. Daily, or when information warrants, the SPOE connects electronically to the CRO and transfers information that triggers the CRO to generate an authorization.

Authorizations are a reflection of the services identified on an IFSP. All service providers/practitioners must have a copy of the IFSP as they begin services for a child and family.

Authorizations will follow and must match the services specified on the IFSP including the dates of service, frequency, intensity, location, and duration.

Authorizations that are inconsistent with the IFSP should immediately be discussed with the service coordinator. The child's service coordinator is identified on the IFSP. The authorization effective date will be the later of the parent's signature or the physician's signature date.

Practitioners should pay close attention to the end dates of the IFSP and authorization and should not extend services beyond the end dates if no new IFSP has been received. Services, other than assessment/evaluation/IFSP development, not covered by an IFSP, are not considered reimbursable services.

Providers should refer to the *First Steps Service Definitions* for specific descriptions of requirements and of billable activities by individual Early Intervention service. Services billed by time must be billed for the period of time that actual services were provided to the eligible child and/or family, and should not include time spent in travel to or from the setting. The Family and Social Services Administration (FSSA) has established a rate reimbursement policy that reflects a higher maximum rate of reimbursement for services provided in the child's natural setting.

Providers continue to be responsible for obtaining PA where PA is required. A separate document exists detailing the PA requirements for early intervention and may be requested by calling the Bureau of Child Development (BCD) at 1-800-441-7837.

Providers can view **Authorizations** on Web interChange to see authorized dates and procedure codes. For authorizations created on or after February 1, 2006, Web interChange also displays how many units or dollars have already been billed on previous claims for PAs that were approved on or after February 1, 2006.

To view information on authorizations for a member, go to the Web interChange *Prior Authorization Inquiry* window (Figure 3.1). This window allows the user to search for a member's authorizations. Enter the member ID and service date and click the **Search** button. The search requires entry of the provider number and member ID.

Figure 3.1 – Web interChange Prior Authorization Inquiry Window

By clicking the **Search** button, the system returns all the authorizations for that member. If the **Service Date** is entered, the returned list includes only authorizations for that date of service. From the list, select an authorization to see how much is authorized and how much has already been used. To select an authorization, highlight the **PA#** and click. See Figure 3.2.

Prior Authorization Inquiry - Microsoft Internet Explorer provided by EDS Indiana Title XIX

File Edit View Favorites Tools Help

Back Forward Stop Search Favorites Local intranet

Address <http://interchange-test.ihcp.inxix.sod.eds.com/PA/PriorAuthList.asp?PageNumber=1&ProvIDHold=200728410&ServLocHold=&RIDHold=9501234567> Go

Prior Authorization Inquiry

[interChange Home](#)
[Indiana Medicaid](#)
[Administration Menu](#)
[Birth Expenditures](#)
[Check Inquiry](#)
[Claim Inquiry](#)
[Claim Submission](#)
[Eligibility Inquiry](#)
[File Exchange](#)
[MRT Correction](#)
[PA Inquiry](#)
[PA Submission](#)
[PASRR Correction](#)
[Provider Profile](#)
[User Lists](#)
[User Profile](#)
[Help](#)
[FAQ](#)
[How to Obtain an ID](#)
[Contact Us](#)
[Logon](#)
[Logoff](#)
[Change Password](#)

Provider/Member ID/Request

Provider Number

Member ID

Confirmation #

PA #

Request Information

Procedure Code

Revenue Code

Service Date

Assignment Code

Modifiers

Search **Reset**

PA#	Confirmation#	Member ID	Start Date	End Date	Amount	Units	Status
F100978054		950123456789	01/01/2006	01/07/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	01/08/2006	01/14/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	01/15/2006	01/21/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	01/22/2006	01/28/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	01/29/2006	02/04/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	02/05/2006	02/11/2006	\$0.00	6.000	APPROVED
F100978054		950123456789	02/12/2006	02/15/2006	\$0.00	6.000	APPROVED
F100978055		950123456789	10/01/2005	10/31/2005	\$0.00	2.000	APPROVED
F100978055		950123456789	11/01/2005	11/30/2005	\$0.00	2.000	APPROVED
F100978055		950123456789	12/01/2005	12/31/2005	\$0.00	2.000	APPROVED
F100978055		950123456789	01/01/2006	01/31/2006	\$0.00	2.000	APPROVED
F100978055		950123456789	02/01/2006	02/28/2006	\$0.00	2.000	APPROVED
F100978055		950123456789	03/01/2006	03/22/2006	\$0.00	2.000	APPROVED
F100978084		950123456789	01/01/2006	02/15/2006	\$0.00	12.000	APPROVED

Helpful Hints

- Click on any field label to get more information about the field.
- Review the [Help Page](#) to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).

Done Local intranet

Figure 3.2 – Web interChange Prior Authorization Provider/Member List Window

The *Prior Authorization Inquiry* window (Figure 3.3) shows the *Start Date* and *End Date* of service, the billable *Procedure* codes, units or dollars authorized (*Units Auth*), and how many units or dollars have already been used (*Units Used*) by previously paid claims for PAs that were approved on or after February 1, 2006.

Prior Authorization Inquiry - Microsoft Internet Explorer provided by EDS Indiana Title XIX

Back Search Favorites AutoLink AutoFill Options

Prior Authorization Inquiry

Provider/Request Information		Patient Information			
Provider Number:	200728410	Member ID:	950123456789		
Provider Name:		Member Last Name:	DOE		
Confirmation #:		Member First Name:	JOHNNY	Member Middle Init:	M
PA #:	F100978054	Member Gender:	M	Member Birth Date:	10/18/2004

Detail Information									
Status	Procedure	Modifiers	Rev. Code	Start Date	End Date	Units Auth	Units Used	Amount Auth	Amount Used
1 APPROVED	92507	TL 52		01/01/2006	01/07/2006	6.000		\$0.00	
	92526	TL 52							
2 APPROVED	92507	TL 52		01/08/2006	01/14/2006	6.000		\$0.00	
	92526	TL 52							
3 APPROVED	92507	TL 52		01/15/2006	01/21/2006	6.000		\$0.00	
	92526	TL 52							
4 APPROVED	92507	TL 52		01/22/2006	01/28/2006	6.000		\$0.00	
	92526	TL 52							

Close

Helpful Hints

- Click on any field label to get more information about the field.
- Review the [Help Page](#) to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).

Figure 3.3 – Web interChange Prior Authorization Detailed Inquiry Window

Section 4: Billing Instructions

Overview

All Early Intervention services authorized through the system point of entry (SPOE) are paid by the Central Reimbursement Office (CRO). The CRO pays the claim, determines the appropriate funding source, and seeks reimbursement. Providers are not to bill Medicaid, insurance and CSHCS, or any other source for early intervention services authorized through the SPOE/EDS.

Claims Processing Turnaround

All providers must be enrolled in the First Steps program as valid providers. All First Steps claims must be submitted electronically, using Web interChange or the 837P transaction. First Steps claims must be submitted with the unique First Steps member identification number (child ID number) that begins with **950**.

Clean claims that are processed by 4:30 p.m. on Friday will be adjudicated and appear on the following weeks Remittance Advice (RA) Statement. Providers may submit claims 24 hours a day, seven days a week. Any First Steps claims that are received on paper arre returned to the provider (RTP).

Procedure Code 99199, unlisted reports, will suspend for Audit 6000, which will require manual pricing. These claims will be processed within 21 business days from the date the claim is received.

Stale Dated Checks

Although electronic funds transfer (EFT) is mandatory for all First Steps Providers, a provider may temporarily receive a paper check. If a check is not cashed within six months (180 days), the check is voided due to stale dating. Once a check is voided, all claims associated with that check are also voided and it is the responsibility of the provider to resubmit the claim(s) in order to receive payment. Resubmission of these claims are subject to the claim filing deadline as defined in this section of the manual.

Claim Filing Deadline

Providers must submit claims for First Steps within 60 days of the date of service. Claims submitted on or after the 61st day following the date of service are denied with edit *512-Your claim was filed past the filing limit without acceptable documentation*.

The filing limit is strictly enforced. Claims that are past the 60-day filing limit must be approved by the First Steps program in order to be processed.

Claim Resubmission Filing Deadline

There is no filing limit for void requests. There is a 180-day filing limit for replacement requests. The system compares the date of service and the date of the current activity to make sure that 180 days have not passed. If replacement claims are past the filing limit (greater than 180 days), Web interChange does not display a **Replacement** button.. These replacements must be submitted to the First Steps program for approval.

Providers have 180 days from the original date of service to replace claims. Providers can void a claim at any time. Voids and replacements can be performed on **paid** claims only. Voids and replacements can be performed to correct incorrect or partial payment, including zero dollar amount. Denied line items on a CMS-1500 claim form must be billed as a new claim, except when specific services must be billed together on one claim form. A void and replacement can be completed on the same day, or in the same week as a claim submission and after payment has been finalized. New region codes are assigned to post financial claims for electronic voids or replacements. A void or replacement must be submitted electronically by utilizing the Web interChange or the 837P transaction.

Voids

A void is a cancellation of an entire claim. Note the following concerning voided claims:

- A void cancels a claim.
- A denied claim cannot be voided.
- A denied claim can only be replaced via the electronic method using electronic data interchange (EDI) or Web interChange.
- If the original claim being voided is in a paid or suspended status and it is the same day or same week, a new claim is not created.
- The same internal control number (ICN) is used.
- The original claim denies with edit *0120 – Claim denied due to an electronic void request*.
- If the original claim being voided is a historical claim, a new claim is created.
- The new ICN starts with **63**.

Table 4.1 – Voids

Pre-Financial	Post-Financial
2005010000002 – Paid	2003002001001 – Paid
Denied with EOB 0120	Today's date: January 10, 2005 6305010001000 – Denied with EOB 0120
RA/835 shows: Claim shows on the denied page only – same ICN.	RA/835 shows: 2003002001001 and 6305010001000 on the adjustment page.

Replacements

Replacement is a change to an original claim, whether same day, same week, or post financial. The original claim indicates the most recent ICN assigned to that claim. An electronically-submitted replacement claim can be for a previously submitted electronic or paper claim. Only non-check-related replacements are accepted electronically. If EDS receives a replacement claim for an original claim that has been through a financial process (has appeared on an RA), the replacement claim ICN starts with one of the following:

- **61** – Provider-initiated replacement containing attachments and/or claim notes
- **62** – Provider-initiated replacement with no attachments and/or claim notes

Table 4.2 – Replacements

Pre-Financial	Post-Financial
2005010222111 – Paid	2005010222111 – On denied page with EOB 0121
2005010222111 – Replacement request submitted and claim is denied with EOB 0121	2005010333444 – On paid or denied page RA/835 shows:
Claim resubmitted – New ICN 2005010333444	2004360111555 – Mother claim
2004360111555 – Paid	6205010666777 – Daughter claim
6205010666777 – Paid	Both appear on the adjustment page
RA/835 shows:	

Claim Overpayment Automated Refund Deadline

Claim overpayment adjustments are entered in the system against individual claims and the system deducts the amount of overpayment on subsequent claim(s) payments processed. If claim(s) payments are not enough to satisfy the overpayment amount within 15 days from the overpayment setup date, providers should send a check in the amount of the overpayment to reimburse the amount of the overpayment.

Claim Underpayment

In cases of underpayments, adjustments are entered in the system against individual claims and the system augments the amount of the underpayment on the next claim payment(s) processed.

Claim Overpayment Manual Refund Deadline

When automated claims adjustment/offset does not satisfy the outstanding portion of the overpayment within 15 days from the overpayment setup date, the provider is mailed a written notice to refund the overpayment discovered by EDS. The provider may also receive a phone call from EDS to recover the outstanding overpayment amount. All manual refunds must be made to EDS no later than 15 days from original overpayment setup date to prevent the provider's accounts from going into collections and or referral to the Office of the Attorney General.

When submitting manual claims corrections for overpayment make the refund check payable to:

**EDS Refunds
P. O. Box 2303, Dept 130
Indianapolis, IN 46206-2303**

Taxonomy

The use of taxonomy is required on all claim submissions, except for assistive technology services. Taxonomy is a unique 10-digit alphanumeric administrative code set that classifies health care

providers by type and area of specialization. The code is structured into the following three distinct levels:

- Provider Type
- Classification
- Area of Specialization

An example of a taxonomy code for a Provider Type – Physical Therapist, Area of Specialization – Pediatrics, is 2251P0200X.

A provider may have more than one healthcare provider taxonomy code. Taxonomy does not appear on the provider's RA. First Steps providers can access the First Steps code crosswalk to determine taxonomy/procedure code combinations on the First Steps Web site at <https://www.infirststeps.com>.

Procedure Codes

All claims must be billed using the proper Health Care Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT[®]) codes.

- Effective February 1, 2006, all claims must be billed using the proper CPT code or HCPCS code for assistive technology services.
- Providers may no longer use local codes to bill First Steps services.
- A list of the proper CPT/HCPCS codes is available on the First Steps Web site at: <https://www.infirststeps.com>.
- All services provided to First Steps members continue to require Authorization from the SPOE.

Modifiers

All claims for First Steps must be billed with the *TL - Early intervention/individualized family service plan* modifier. When billing for services that are measured in minutes, the 52 modifier must be included. When billing for services measured in minutes, one unit equals 15 minutes. When billing for services that are provided in a group setting, the modifier *HQ* must be included on the claim. For example, if a provider renders 45 minutes of treatment for speech language, voice communication the provider bills:

- CPT Procedure Code = 92507 TL 52
- Units Billed = 3

<i>Note: The CPT procedure code 92507 TL 52 has replaced procedure code X8022.</i>
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Place of Service

All First Steps claims must include the proper place of service (POS). POS is used to determine pricing for the claim.

- If the POS is missing from the claim, the claim will deny.

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- POS codes can be found in Table 4.3.

Table 4.3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
01-02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-based Facility
09-10	Unassigned
11	Office
12	Home
13	Assisted Living Facility*
14	Group Home*
15	Mobile Unit
16-19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43-48	Unassigned
49	Independent Clinic*
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center

(Continued)

Table 4.3 – Place of Service Codes

Place of Service Code(s)	Place of Service Name
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility*
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic**
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

* New Place of Service Code, effective September 26, 2003.

** Revised Place of Service code, effective September 26, 2003.

Note: The unassigned Place of Service codes in Table 4.4 are authorized for First Steps billing.

Table 4.4 – Additional Place of Service Codes
Authorized for First Steps Billing

Place of Service Code(s)	Place of Service Name
03	Nursery School/Child Care Center
22 or 11	Outpatient Service Facility
21	Hospital In Patient
95	Family Day Care
97	EI Class/Program
98	Residential Facility

Member Identification Numbers

First Steps claims must be submitted with the unique First Steps member identification number. This number begins with **950**.

Internal Control Number (ICN)

An ICN is assigned to each adjudicated claim. This is the 13-digit number that EDS assigns to track the claim. The first two digits of the ICN are the region code. The region code for claims submitted electronically is **20**. The second and third digits of the ICN are the year. The next three digits are the Julian date. The remaining digits are used internally by EDS to track the claim. An example of an ICN number is 2006010150000.

Billing Methods

All First Steps claims must be submitted electronically. Providers have two options for submitting claims electronically, Web interChange or the Health Insurance Portability Accountability Act (HIPAA)-compliant 837P transaction.

Web interChange

Web interChange is a Web-based application provided by EDS. It is secure, fast, free, and does not require special software. It does require Microsoft Internet Explorer 6.0 or above. Encryption and secured socket layer (SSL) connections protect the data in transit. View the **Help Text** on Web interChange at <https://interchange.indianamedicaid.com> for complete system requirements.

Providers must be enrolled as a First Steps provider and have a First Steps provider number to use Web interChange. Features of Web interChange include:

- Field level help that provides field definition and valid values
- Extensive **Claim Submission Help** and **Frequently Asked Questions (FAQs)**
- Options to void and replace claims

First Steps providers can use Web interChange to submit claims, inquire on the status of submitted claims, view prior authorization (PA), view provider profile, and view check write information.

Claim Submission

Providers using Web interChange submit First Steps claims on the *Professional - Medical Claim* form. Claims can be submitted 24 hours a day, seven days a week. Field editing performed prior to submission helps to ensure *clean* claims. Building user lists to store and retrieve frequently used claim submission data expedites the claim billing process. Claims are entered and submitted one at a time and can be easily copied and edited for resubmission. Printing of claims is available for documenting claim submission for auditing purposes. View the **Help Text** on Web interChange at <https://interchange.indianamedicaid.com> for detailed instructions on building user lists, copying claims, and printing claims.

Figure 4.1 is an example of the Web interChange *Professional Claim* (medical claim) form. The fields for the billing provider number (payee), the rendering provider number, the modifiers and the taxonomy code are noted as additional required fields in Figure 4.2.

Professional Claim - Microsoft Internet Explorer provided by EDS Indiana Title XIX

Back Search Favorites Site popups allowed Options

Google Search Web

Professional Claim

* denotes a required field.

Billing Information
* Provider Number
* Member ID
* Last Name
* First Name
* Patient Account #
Rendering Physician
Referring Physician
Certification Code
* Signature Indicator ☒ Yes ☐ No
Medical Record #
Notes... **Attachments...**

Service Information
Claim Type **Medical**
* Place of Service
Hospital From Date
Hospital To Date
Pregnancy? ☐ Yes ☒ No
Last Menstrual Period
Accident Related to ☐ Auto ☐ Employment ☐ Other Accident
Special Program
Benefit Information
Total TPL
Total Medicare Paid

Billing Codes
Diagnosis Code
Primary
Diag 2
Diag 3
Diag 4
Diag 5
Diag 6
Diag 7
Diag 8
Charges
Total Charges

Detail Information
Detail # 1 * From DOS * To DOS
Place of Service * Procedure Code Modifiers
Related Diagnosis * Units * Charges

Figure 4.1 – Web interChange Professional Claim Window

Professional Claim - Microsoft Internet Explorer provided by EDS Indiana Title XIX

Back Search Favorites Site popups allowed Options

Notes... Attachments... Benefit Information

Detail Information

Detail # 1 * From DOS * To DOS

Place of Service * Procedure Code Modifiers

Related Diagnosis * Units * Charges

* Emergency? Yes No Line Item Control # * EPSTD Referral Yes No

Rendering Physician Taxonomy Unit of Measure

NDC Quantity

Notes... Detail Benefits Info Other Provider Info

Save Detail Reset Detail

Detail # From DOS To DOS Procedure Modifiers Units Charges

Add Detail
Delete Detail
Copy Detail

Submit Claim Reset Claim Cancel Claim

Helpful Hints

- Click on any field label to get more information about the field.
- Review the [Help Page](#) to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).

Rendering Provider Number

Taxonomy

Modifiers

Figure 4.2 – Web interChange Professional Claim Detail Window

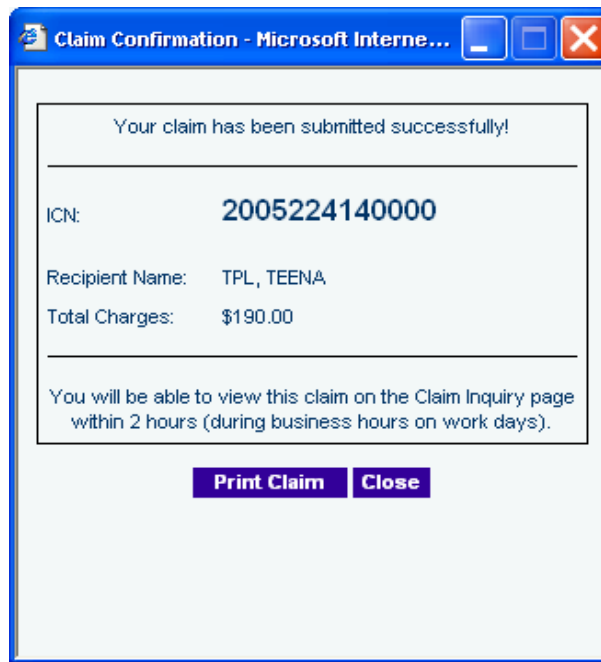


Figure 4.3 – Web interChange Claim Confirmation Window

Upon successful submission of a claim the *Claim Confirmation* screen displays (Figure 4.3) showing the ICN of the submitted claim. The ICN can be used to check on the status of the claim by using the **Claim Inquiry** function of Web interChange.

Claim Inquiry

interChange Home
Indiana Medicaid
Check Inquiry
Claim Inquiry
Claim Submission
Eligibility Inquiry
Provider Profile
User Lists
Help
FAQ
How to Obtain an ID
Contact Us
Logon
Logoff
Change Password

Provider/Member ID/ICN
 Provider Number:
 Member ID:
 ICN:

Claim Information
 Claim Status:
 Claim Type:
 From Date: To Date:
 Date Type:

ICN	Member ID	First Date	Last Date	Billed Amount	Paid Amount	RA Date	Type	Status
2004070059000	4000000000017	09/01/2003	09/01/2003	\$25.00	\$0.00	03/17/2004	Dental	Denied
2003310130001	4000000000029	09/15/2003	09/15/2003	\$190.00	\$78.61	11/18/2003	Outpatient	Paid
2004014130002	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	01/27/2004	Outpatient	Denied
2004014130003	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	00/00/0000	Outpatient	Suspended
2004016130000	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	00/00/0000	Outpatient	Suspended
2004016130001	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	00/00/0000	Outpatient	Suspended
2004020130000	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	00/00/0000	Outpatient	Suspended
2004261130010	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	11/16/2004	Outpatient	Denied
2004274130000	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	10/12/2004	Outpatient	Denied
2004293130000	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	10/26/2004	Outpatient	Denied
2004295130007	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	12/21/2004	Outpatient	Denied
2004295130009	4000000000029	09/15/2003	09/15/2003	\$190.00	\$0.00	12/21/2004	Outpatient	Denied
2303293006000	4000000000016	09/16/2003	09/16/2003	\$3,205.00	\$0.00	10/28/2003	Outpatient Crossover	Denied
2304014006000	4000000000016	09/16/2003	09/16/2003	\$3,205.00	\$0.00	01/27/2004	Outpatient Crossover	Denied

Helpful Hints
 Click on any field label to get more information about the field.

Figure 4.4 – Web interChange Claim Inquiry Window

Claim Inquiry

This feature of Web interChange allows providers to inquire about previously submitted claims within two hours of submission. Providers may search for claims using a date range, claim type, member identification number, or ICN. Claims can be searched by paid, denied, suspended, or any status.

The search results display on the Claim Inquiry window (Figure 4.4). Clicking on the ICN displays detailed information about the claim including amount paid, explanation of benefits messages, and other claim data.

If a claim has been denied, the provider can copy the claim, make the necessary corrections, and resubmit the claim. The provider does not need to wait for the weekly RA to resubmit denied claims.

Prior Authorization

This function of Web interChange allows providers to view the PA status of First Steps members. See *Section 3: Service Authorization*, for detailed information about provider authorization inquiry.

Profile Inquiry - Microsoft Internet Explorer provided by EDS Indiana Title XIX

Profile Inquiry [Close]

Query Information

Provider Number [Inquire]

Provider Information

Enrollment Information

Helpful Hints

- Click on any field label to get more information about the field.
- Review the [Help Page](#) to find more information about how to use this site.
- Please direct comments, problems or suggestions concerning using this site to [Indiana Medicaid](#).

Displays Providers type and specialty information

Displays the names and dates of the programs in which the provider is enrolled

Figure 4.5 – Web interChange Profile Inquiry Window

Provider Profile

Provider profile accessed through the *Provider Inquiry* window (Figure 4.5) allows providers to view their provider information including type and specialty. Groups can view all of the rendering providers associated with their practice.

Figure 4.6 – Web interChange Check Inquiry Window

Check Inquiry

Check inquiry, provided on the *Check Inquiry* window (Figure 4.6), allows the provider to inquire about previously received payments. The provider can locate checks or electronic funds transfers (EFTs) by searching within a date range or by a specific check number. A list of claims associated with each check displays.

Access to Web interChange

Providers who are enrolled in the First Steps program can obtain access to Web InterChange by completing the *Administrator Access Request* form under **How to Obtain An ID** available at <https://interchange.indianamedicaid.com>. Each provider must assign an administrator for Web interChange and must send a note of acknowledgement on company letterhead from the organization's owner indicating approval of the administrator.

Web interChange administrators have the ability to create additional users for their organization, grant necessary permissions to each user, and reset passwords.

Questions about Web interChange can be answered by calling the EDS EDI Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182, select option 2 for Web interChange. Questions can also be submitted electronically by e-mail at INXIXElectronicSolutions@EDS.com.

Testing

All systems used to send batched First Steps 837P transactions to EDS must be tested and approved. Complete software testing procedures can be found on the Indiana Health Coverage Programs (IHCP) Web site at <http://www.indianamedicaid.com> under **EDI Solutions, Software Testing Procedures**.

Trading Partner Profile

First Steps providers exchanging data directly in the 837P format are required to complete and submit a *Trading Partner Profile* to initiate the process for becoming a Trading Partner. The *Trading Partner Profile* is the tool the provider must use to indicate the types of transactions they will exchange and the software they will use. The *Trading Partner Profile* can be found at

http://www.indianamedicaid.com/ihcp/TradingPartner/TP_Profile.asp

Available transactions for First Steps providers are:

- 837P – Health Care Claim Professional
- 835 – Health Care Payment Advice
- 997 – Functional Acknowledgement
- *Biller Summary Report* (BSR) – EDS proprietary report of claim transactions

Detailed information about the 997 transaction and the BSR is available in the *Companion Guide - EDI Reports and Acknowledgements* located at

http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf

Trading Partner Agreement

Providers can choose to submit claims in a batch using the HIPAA-compliant 837P transaction. To exchange data with EDS electronically, using this method, providers must review the requirements and specifications published in the *Companion Guide – 837 Professional Claims and Encounters Transaction*. This document is posted on the IHCP Web site at

<http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/837p.pdf>.

First Steps providers must use an approved software product, billing service, or clearinghouse to exchange data.

First Steps providers who are exchanging data directly in the 837P format or are receiving an 835 electronic remittance transaction are required to complete and mail a *Trading Partner Agreement*. The *Trading Partner Agreement* is a contract between parties who have chosen to become electronic business partners. The *Trading Partner Agreement* stipulates the general terms and conditions under which the partners agree to exchange information electronically. Billing providers must print, complete, and mail a copy of the *Trading Partner Agreement* to the following address:

EDS Trading Partner Agreement
950 North Meridian Street, 10th Floor
Indianapolis, IN 46204

This agreement can be found at

http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_Testing.asp

Trading Partner ID and Login Credentials

Upon completion of testing, EDS assigns each direct submitter a new, unique production trading partner ID, login ID, and password.

Communication

Inbound batch transactions and outbound transactions and reports are exchanged through secure file transfer protocol (FTP). File Exchange is an application used by EDS for secure file processing, storage, and transfer. File Exchange is designed to safely and securely collect, store, manage, and distribute sensitive information. File Exchange allows for encrypted connections using the FTP over secure socket layer (SSL) secure file transfer protocol (FTPS), FTP over secure shell (SSH) secure file transfer protocol (SFTP), and hypertext transfer protocol (HTTP) over SSL secure hypertext transfer protocol (HTTPS) protocols. Complete information about using File Exchange can be found in the *Companion Guide - EDI Communication* at

<http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/comm.pdf>

Questions regarding batch claim submission should be sent to INXIXTradingPartner@eds.com or by contacting the EDS EDI Solutions Help Desk at (317) 488-5160 or 1-877-877-5182.

Remittance Advice

On Tuesday of each week, EDS generates and mails a provider Remittance Advice (RA) which details the information on the claims submitted and processed. The RA contains comprehensive billing information concerning the recipient's disposition of a provider's submitted IHCP claims. An Electronic Remittance Advice (835) is also available to the provider upon request.

Section 5: Calculation of Units Encountered

Overview

This section is provided to assist providers with the management of services delivered and billed.

For those authorizations created on or after February 1, 2006, the provider should use Web interChange **Prior Authorization (PA) Inquiry** to track the utilization of services. Because it is the responsibility of providers to monitor the utilization of services they have been authorized to deliver, it is essential that they receive information on the process by which the total units on an authorization are calculated.

The majority of authorization types, created before February 1, 2006, are addressed by the information below. However, in the case of assistive technology, authorizations are based on fixed dollar amounts for specific items.

Background

The information in this section pertains only to authorizations created prior to February 1, 2006. All corresponding authorizations created after February 1, 2006 are tracked by the time period intervals of per authorization, daily, weekly, monthly, quarterly, and yearly instead of one lump sum for the entire authorization. Therefore, the algorithm discussed here does not apply to authorizations created after February 1, 2006.

The new mainframe database determines the maximum usage of many types of authorization based on a calculated number of units authorized. For example, an authorization for a service to be rendered 3 times for 1 hour each time would have a total *units authorized* of 12 units (4 15-minute units x 3 visits).

Once all units authorized have been paid, claims are denied with reason code 3000.

The system point of entry (SPOE) software has enormous flexibility in the specification of an authorization's number of units. An authorization can be written for X units, Y times per Z time period, from a start date to an end date. This flexibility adds a great deal of complexity when calculating the maximum number of units intended to be authorized.

Most of the calculation is simple. Determining precisely (and programmatically) how many weeks, months, quarters or years fall between the start date and end date is another matter.

Usually, the difference in total units authorized that results from a variance of plus or minus a week or month is relatively minor. In some cases, the difference can be quite large, particularly when the authorization is written on a per-month, per-quarter or per-year basis.

Examples

1. 4 units, 8 times per month from 3/10/01 to 5/25/01
Totals 96 units, if the date range is rounded to 3 months
64 units, if the date range is rounded to 2 months
48 units, if the date range is prorated to 1.5 months

2. 2 units, 52 times per year from 2/1/00 to 1/12/01

(An actual authorization very much like this one raised the issue)

Totals 52 units, if rounded to 1 year

104 units, if rounded to 2 years

49 units, if prorated to 0.95 years

Solution

An algorithm for converting a specified date range into a number of weeks, months or years was agreed upon and implemented. An effort was made to keep the algorithm simple, because the number of units authorized must be calculated each time a claim is edited to determine whether it can be paid.

In order to address the above requirements and considerations the following algorithm has been implemented in *Mainframe Database*:

Coding Intermediate Values

U = the number of units authorized per single time period. In example 1., above, U = 32 (4 units x 8 times per single month). In example 2., U = 104 (2 units x 52 times per single year). In finding U, the start and end dates of the authorization and the exact time period specified are ignored. For any authorization, U is an integer that is easily determined.

T = the number of time periods falling between the authorization start date and end date. It is not rounded, and it is determined as follows:

- If start date = end date or the time period is *per auth*, then T = 1, *else*
- T = the number of days between start date and end date, inclusive, divided by 1, 7, 30, 90, or 365, for authorizations per day, per week, per month, per quarter and per year, respectively.
- Total Units Authorized = $U \times T$. The number of units per time period multiplied by the number of periods between the start date and end date gives the final answer.

When any remainder exists, the number of units is always rounded up to the next whole number. For instance, 14.01 units should be paid up to 15 units.

This algorithm effectively prorates the units authorized according to the number of days in the authorization's date range, giving the third answer in the examples.

Summary

The last section above describes the calculation, which is this:

$U \times T$ where

- U = the number of units per time period (per auth, per week, per year,...)
- T = the number of time periods during the authorization, based on the number of days from start date to end date, divided by 7, 30, 90, or 365 to determine weeks, months, quarters, or years, as appropriate.
- If the result of $U \times T$ is not an integer (0 to the right of the decimal), the value is always bumped up to the next whole unit.

The following are examples:

1. 45 minutes 2 times per week, from April 1 to May 31

$$U = 6 \text{ (3 units} \times \text{2 times per)}$$

$$T = 8.7142857 \text{ (61 days} \div \text{7 days per week)}$$

$$U \times T = 52.2857...$$

$$\text{Units Authorized} = 53$$

2. 60 minutes 2 times per month, from February 1 to May 31 $U = 8$ (4 units \times 2 times per)

$$T = 4.0 \text{ (120 days} \div \text{30 days per month)}$$

$$U \times T = 32.0$$

$$\text{Units Authorized} = 32$$

3. 30 minutes 5 times per authorization, from January 1 to December 31 $U = 10$ (2 units \times 5 times per)

$$T = 1.0 \text{ (time period is per authorization)}$$

$$U \times T = 10.0$$

$$\text{Units Authorized} = 10$$

- D. 90 minutes 1 time per quarter, from January 1 to January 31 $U = 6$ (6 units \times 1 time per)

$$T = 0.34444... \text{ (31 days} \div \text{90 days per quarter)}$$

$$U \times T = 2.06666...$$

$$\text{Units Authorized} = 3$$

Glossary

1500 or CMS-1500	This is a claim form used by participating IHCP providers to bill medical and medically-related services.
A/R	Accounts receivable.
Active Child Status	Child records available for update on the SPOE machine.
ACN	Attachment Control Number – an unique number assigned for the attachment for a claim that was submitted electronically.
Access	Term used to describe the action of entering and using a computer application.
Ad Hoc Report	A user-configured query to obtain data. A non-standard report requested by a customer or vendor that is not part of any routine reporting.
Adjudicate	To process a claim to pay or deny.
Adjustment	A transaction that adjusts and reprocesses a previously processed claim; The contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims
Adjustment Recoupments	Recoupments set up by the adjustments staff to reclaim payments made in error through the adjustment process. A record of these recoupments is maintained by the Cash Control System until zero-balanced.
Advanced Information Management	<i>AIM</i> . The State's current MMIS, referred to as Indiana <i>AIM</i> .
AG	Attorney General.
Aggregation Codes	System codes that classify the providers rendering services to members.
Aid Category	A designation within the State Social Services Department under which a person may be eligible for public assistance and medical assistance.
AKA First	Also known as other first or nickname of the child.
AKA Last	Also known as other last name for the child.
AKA MI	Also known as other middle initial for the child.
Allowed Amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure
Alpha	Data comprised of letters only.
Alphanumeric	Data comprised of numbers and letters.
ARC Code	Adjustment Reason Code- National code that explains modification to a claim.

Authorization	An authorization allows a provider to provide services and care the child with disabilities and/or developmental delays. Providers are paid for their services by billing authorizations. SPOE sites enter authorizations into the SPOE software and to the provider. The provider then has a record of what services have been approved. If there is not an authorization for a service for that provider, no payment is sent to the provider who provided services.
Authorization Number	System generated number for tracking authorizations through claim payment.
Authorization Service Type	The type of service a provider is providing for a child.
Automated Voice Response	AVR. Computerized voice-response system used by providers to obtain pertinent information by telephone. The system provides information concerning member eligibility, benefit limitation, information, and PA for those participating in the IHCP.
Bank Identification Number	BIN. Bank identification number or card issuer identification number used for network routing.
Batch Status Reports – Invalid Records	Report listing of records that contained errors that could not be included in the batch report that is sent to EDS during the communication process.
Batch Status Reports – Invalid Records	Report listing of records that contained errors that could not be included in the batch report that is sent to EDS during the communication process.
Batch Status Reports – Valid Records	Report listing of records that were included in the batch report that is sent to EDS during the communication process.
Bill	A statement of charges for medical services, the submitted claim document, or electronic record, which may contain one or more services performed
Billed Amount	The amount of money requested for payment by a provider for a particular service rendered.
Billing Provider	The party responsible for submitting to the department the bills for services rendered to an First Steps' child.
Billing Service	An entity under contract with a provider that prepares billings on behalf of the provider for submission to payers.
Birth Date	Date of birth for the individual.
Cap	A finite limit on the number of certain services for which the department pays for a given member per calendar year.
Care/Service Coordinator	Person designated to coordinate, enable, and assist the child who is eligible for Early Intervention services, and the child's family. The person is responsible for overseeing the rights, procedural safeguards, and services that are authorized to be provided through the First Steps program.

Carrier	In the SPOE software, Carrier refers to the name of the insurance company which covers the health insurance for the child.
Case Management	A process whereby covered persons with specific health care needs are identified, and a plan that efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
Case Manager	An experienced professional (for example, nurse, doctor, or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care
Case Type	A set of criteria that group claims billed for members within a predefined group. Such groups include services performed, diagnosis codes, provider types, or other parameters. Case types are not exclusive and can overlap since claims may be included in more than case type grouping.
Cash Control Number	CCN. Financial control number assigned to uniquely identify individual transactions, including all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
Cash Control System	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
Child ID	Unique identifier generated by the SPOE software. The first four digits contain the SPOE ID of the computer on which the child's records was created.
Child Computer/Machine	A parent computer can be either a laptop or a desktop computer and is considered the SPOE's main computer. The SPOE's sites usually enter the authorizations and IFSP's on the parent machine. The child machine is typically a laptop and is used for doing the Intake work in the field for a child. The SPOE staff might go out to a child's home or other site. When the child machine does an end of the day, the new records are batched and sent to EDS. On the laptop, the records are flagged as no update status. The information is then sent to the parent machine during the communications and the child status on the parent machine is set to active. Child records can only be updated on the parent machine when this process is complete.
Claim Correction Form	CCF. Automatically generated by IndianaAIM for certain claim errors and sent to the provider with the weekly RA. Allows the provider an opportunity to correct specified errors detected during the claim processing cycle.
Claim Note	Providers can send a note on designated claim situation
Claim Remark Code	Remark that explanation of claim payment (HIPAA)
Claim Transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.

Claims History File	Computer files of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
Clean Claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
Clear Work Tables	Menu option that clears the temporary tables created and used by reports.
CMS	Centers for Medicare and Medicaid Services.
CMS-1500	CMS-approved standardized claim form used to bill professional services. Formerly referred to as HCFA-1500.
CO	Change Order.
Communication Log File	Report that is displayed and/or printed showing all of the activities that occurred during the last communications session.
Communication Session	Combination of all of the processes used to transmit files via an internet connection to the EDS server.
Compact Work Tables	Over time, as records are created and deleted, the SPOE access database file gets inflated with empty space, and the “compact” utility is designed to reduce the size of the database file. Most users run this only when instructed by the help desk, it can be beneficial to run this on a regular basis. Like the windows “defrag” utilization helps to speed things up. Because the database file is zipped as it is backed up on floppies, the smaller .mbd size should translate to fewer backup disks.
Computer-Output Microfilm	COM. The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
Contact Tracking Management System	CTMS. A system designed to electronically track documents from the point of receipt through completion. The tool is used to assist with contractual compliance and accountability. This system is distinct from the document management system.
Co-payment, Co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered.
County Office	County Offices of the Division of Family Resources. Offices responsible for determining eligibility for Medicaid using the ICES. See <i>CDFR</i> .
Credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CSW	Certified Social Worker

CTMS	Contact Tracking Management System. A system for tracking documents submitted to EDS by outside contacts from the point of receipt to closure. The tool is used to assist with contractual compliance and accountability. This system is distinct from the document management system.
Database	A collection of data arranged for ease and speed of search, entry, and retrieval.
Data Element	A specific unit of information having a unique meaning.
Data Processing Overnight Commission	DPOC. Indiana State agency that oversees agency compliance with all State data processing statutes, policies, and procedures.
Date of Service or Service Date	DOS. Actual date on which a service is rendered to a particular member by a particular provider.
Detail	Specific information stating explicitly which services are approved for the authorization.
Diagnosis	Investigation or analysis of the cause or nature of a condition, situation, or problem.
Digit	Any symbol that expresses an idea or information, such as letters, numbers, and punctuation.
Disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
Disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
Drill Down	A system capability that allows the user to obtain more detailed or in-depth information from a query and subsequent report.
Duplicate Claim	A claim that is either totally or partially a duplicate of services previously paid.
Eastern Standard Time	EST. Indianapolis local time, is a constant in the majority of the state of Indiana. From the last Sunday in April to the last Sunday in October Indianapolis is on the same time as the states observing CST, like Illinois. From the last Sunday in October to the last Sunday in April Indianapolis is on the same time as the states observing EST, like New York. Currently, Indiana does not observe daylight savings time.
Education	Highest attained or current year of education for the individual.
Electronic Claims Capture	ECC. Refers to the direct transmission of electronic claims over phones lines to IndianaAIM. ECC uses point-of-service devices and personal computers for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
Electronic Claims Management	ECM. Overall management of claim transmittal via electronic media; related to ECS, EMC, ECC, paperless claims.

Electronic Claims Submission	ECS. Claims submitted in electronic format rather than paper.
Electronic Data Interchange	EDI. EDI is the transfer of data between different companies using networks , such as the Internet . ANSI has approved a set of EDI standards known as the X12 standards.
Electronic Data Processing	EDP. Data processing using computers with the end result of collected data for access, display, reporting, and manipulation.
Electronic Funds Transfer	EFT. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
Electronic Media Claims	EMC. Claims submitted in electronic format rather than paper.
Eligibility	Qualification for the Early Intervention program.
Eligibility File	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
Eligibility Type	Specific reason by type, which the child qualifies for the Early Intervention program.
Eligibility Verification System	EVS. A system used by providers to verify member eligibility using a point-of-sale device, on-line PC access, or an automated voice-response system.
End of Day	Complication of processes that include backup, creation of batch files, communications, and post-communications processes to run unattended when the End of the Day is initiated.
EOB	Explanation of benefits.
Error Code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
Errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example, claims with data discrepancies or claims held up for investigation of possible third-party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design.
Expected Reimbursement Amount	A statistically estimated amount that represents the amount the reimbursement that a provider is expected to receive for services rendered based on the age and gender mix of patients and the actual reimbursement received by the provider peer group.
Explanation of Benefits	EOB. An explanation of claim denial or reduced payment included on the provider's RA.
Explanation of Payment	EOP. A term previously used by the IHCP for the Claim Summary Statement. Now called the RA. Other insurers continue to use the term for claim statements to providers.

Export	A system feature that enables the user to transfer results of a query to an external file that can be imported and used by another application.
Family and Social Services Administration	FSSA. The OMPP is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the IHCP.
Family Assistance Management Information System	FAMIS. System used as part of the TANF program.
Financial Adjustment Reason Codes (ARC)	Two character alphanumeric codes associated with financial transactions and activities that can increase or decrease a payment.
Financially Responsible	The person legally responsible for the financial expenses of the child.
First Name	Child's legal first name.
First Steps Program	Indiana's First Steps System provides early intervention for families which have infants and toddlers with developmental delays or who show signs of being at-risk to have certain delays in the future. Indiana's First Steps is a family-centered, coordinated system to serve children from birth to age 3 who have disabilities and/or who are developmentally vulnerable.
Front End	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
Front-End Process	All claims system activity that occurs before auditing.
Gender	Determined sex of the individual.
HCPCS Code	Type of procedure code used for reporting medical services to Medicare and Medicaid.
Head of Household	Person in charge, usually a parent, living in the same household as that of the child.
Header	Identification and summary information at the head (top) of a claim form or report.
Health Insurance	Includes, but is not limited to, coverage by any health care insurer, Health Maintenance Organization, or an employer-administered ERISA plan.
Health Insurance Portability and Accountability Act	HIPAA. The Health Insurance Portability and Accountability Act of 1996 is a set of rules to be followed by health plans, doctors, hospitals, and other health care providers. HIPAA took effect on April 14, 2003. In the health care and medical profession, the great challenge that HIPAA has created is the assurance that all patient account handling, billing, and medical records are HIPAA compliant.
Household Member	Person living in the same household as the child.

ICD-9 Code	Code approved for reporting diagnosis for medical procedures to Medicare and Medicaid programs.
IDEA	The Individual with Disabilities Education Act (IDEA) is a federal law that guarantees all students between the ages of 3 through 21 with disabilities have the right to a free and appropriate public education designed to meet their individual needs.
Import System Files	SPOE function that processes report updates or internal table updates that exist as files in the “down send” directory. The process runs automatically during post-communications when these files are received via the communication process. The menu item was added to ease the installation of the files when distributed via a floppy disk. The SPOE operator should use this option only when instructed by the help desk or by some distribution documentation.
Indiana Client Eligibility System	ICES. Caseworkers in the local CDFRs use this system to help determine applicants’ eligibility for medical assistance, food stamps, and TANF.
IndianaAIM	Indiana Advanced Information Management system. The State’s current MMIS.
Individualized family service plan (IFSP)	IFSP. Documents and guides the early intervention process for children with disabilities and their families. The IFSP is the vehicle through which effective early intervention is implemented in accordance with Part C of the IDEA. It contains information about the services necessary to facilitate a child's development and enhance the family's capacity to facilitate the child's development. Through the IFSP process, family members and service providers work as a team to plan, implement, and evaluate services tailored to the family's unique concerns, priorities, and resources.
Individualized Program Plan	IPP. The interdisciplinary team must prepare an IPP, which includes opportunities for individual choice and self-management, and identifies: the discrete, measurable, criteria-based objectives the individual is to achieve; and the specific individualized program of specialized and generic strategies, supports, and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention or deceleration of regression or loss of current optimal functional status.
Inquiry	Type of online screen programmed to display rather than enter information. Used to research information about members, providers, claims adjustments, and cash transactions.
Insurance Carrier	Name of the insurance company who carries the child’s health insurance.
Insurance Deductible	Specified dollar amount of payable expenses by the insured prior to the insurance company remitting payment for services rendered by the health care provider.
Insurance Group Number	Additional number used to identify the insured policy, especially if covered through the employer

Insurance Policy Number	Identifying number used by the insurance company to identify the policy of the insured. Typically includes the insured persons social security number.
Insurance Type	Identifying specific coverage of the insurance plan.
Intake	Process of identifying, gathering, and evaluating information relating to the needs and qualifications of a child entering the Early Intervention program. Intake is a pre-requisite for IFSP's and Authorizations.
Intake Service Coordinator	Person designated to record the information for the intake of a child entering the Early Intervention program.
Internal Control Number	ICN. A unique number assigned to each transaction in IndianaAIM.
Interim IFSP	The Interim IFSP (Individualized family service plan) is to allow authorization of services that are needed within the time frame before a full fledged IFSP can reasonably be developed. It could be considered an emergency IFSP.
Itemization of Charges	A breakdown of services rendered that allows each service to be coded.
Last Name	Child's Last Name
Legally Responsible	Person responsible for the child as defined by law (parent, foster parent, legal guardian).
Line Item	A single procedure rendered to a member. A claim is made up for one or more line items for the same member.
Location	Location of the claim in the processing cycle such as paid, suspended, or denied.
Management and Administrative Reporting Subsystem	MARS. A federally mandated comprehensive reporting module of IndianaAIM that includes data and reports as specified by federal requirements.
Manual Backup	Backup process that is performed without running the end of day process.
Medicaid or Medical Assistance Program	Medicaid is a federal-state mandated medical assistance program administered by the State to provide reasonable and necessary medical care for persons meeting medical and financial eligibility requirements pursuant to federal law, 42 U.S.C. 1396 and state law, IC 12-15. The Medicaid program in Indiana is known as Indiana Health Coverage Programs (IHCP).
Medicaid covered service	A service provided or authorized by an IHCP provider for an IHCP enrollee for which payment is available under the IHCP as set forth in 405 IAC 5. A list of covered services is referenced in IC 12-15-5-1.
Medicaid Management Information System (MMIS)	The IHCP payment and information system of the Indiana Family and Social Services Administration; also known as IndianaAIM.
Medicaid Recipient/Indiana Health Coverage Programs Enrollee	An IHCP enrollee in one of these aid categories: Aged; Blind and Disabled; Temporary Assistance for Needy Families; Pregnancy Medicaid; Children's Medicaid.

Menu	Online screen displaying a list of the available screens and codes needed to access the online system.
Menu Bar	Microsoft standard terminology for the horizontal list of words representing groups of options that displays across the top of a Windows application, above the toolbar. Clicking on the word accesses a menu of options.
MI	Child's Middle Initial.
MMDDYY or MMDDCCYY	Format for a date to be reflected as month, day, and year such as 091505. Format for a date to be reflected as month, day, century, and year such as 09152005.
Module	A group of data processing or manual processes that work in conjunction with each other to accomplish a specific function.
Mothers Maiden Name	Maiden or non-married name of the child's mother.
Multiple Detail Authorization	Authorizations with more than one detail attached to them.
New Detail	Additional detail added to an existing authorization.
No Update Child Status	Child's record must be updated on the parent machine. No changes to the record will be saved.
Object	An individual data source such as a provider number, procedure code, or date of service.
Overpayment	An amount included in a payment to a provider for services provided to a First Steps child resulting from the failure of the contractor to use available information or to process correctly.
Override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
PA	Prior authorization.
Paid Amount	Net amount of money allowed by First Steps.
Paid Claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by First Steps that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
Paperless Claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
Parameter	Factor that determines a range of variations.

Parent Computer	A parent computer can be wither a laptop or a desktop computer and is considered the SPOE's main computer. The SPOE's sites usually enter the authorizations and IFSP's on the parent machine. The child machine is typically a laptop and is used for doing the Intake work in the field for a child. The SPOE staff might go out to a child's home or other site. When the child machinedies an end of the day, the new records are batched and sent up to EDS. On the laptop the records are flagged as no update status. The information is then sent to the parent machineduring the communications and the child statuson the parent machine is set to activate. Child records can only be updated on the parent machine when this process is complete.
Password	A string of alphanumeric characters, coupled with a login ID, to create a unique identity of a user of a computer, network, or Internet.
Payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
Pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
Primary Diagnosis	Primary being first in order of importance, diagnosis being the determination of the nature of a case of disease.
Primary Program Eligibility	Most important reason the child is eligible for the Early Intervnetionprogram.
Primary Referral Source	First source of the referral.
Print-Out	Approval number given prior to the actual services being rendered.
Prior Approval Number	Reports and information printed by the computer on data correlated in the computer's memory.
Prior Authorization	PA. An authorization from First Steps for the delivery of certain services. The Medical Services Contractor and State medical consultants review PAs for medical necessity, reasonableness, and other criteria. The PA must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances.
Processed Claim	Claim where a determination of payment, nonpayment, or pending has been made.
Profile	Total view of an individual provider's charges or a total view of services rendered to a member.
Provider	Person designated to supply a service, or make it available.
Query	An inquiry for specific information not supplied on standardized reports.
R/A	Remittance and Status Report.
RA	Remittance advice.

Re-Batch All Children's Records	Menu option that flags all of the records in the SPOE database. The next time the end of the day process is run, the flagged records are included in the file that is communicated to EDS during the communications process,
Re-Batch One Child's Records	Menu option that flags the child's record so that the next time the end of the day process is run, the flagged record is included in the file that is communicated to EDS during the communication process.
Recipient Identification Number or Member Identification Number	RID. The unique number assigned to a member who is eligible for IHCP services.
Referring Provider	Provider who refers a member to another provider for treatment service.
Refresh	To obtain and add current data to a previously run query.
Regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or a procedure.
Reimbursement	Payment made to a provider, pursuant to federal and State law, as compensation for providing covered services to members.
Reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents.
Rejected Claim	Claim determined to be ineligible for payment to the provider; contains errors, such as claims for non-covered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
Remittance Advice	R/A. A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks and denials. The provider receives a check enclosed in the R/A when claims are paid.
Rendering Provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
Repair Database	Menu option that initiates the SPOE software to execute the "compact" or "repair" Microsoft Access utilities. This can be used to solve data problems even while the SPOE PC does not have Microsoft Access installed. Over time, as records are created and deleted, the Access database file increases in size, the compact feature reduces the size of the database to the actual data size. This process is like the Windows "defrag" application, and may help to speed things up as the database grows. The "repair" utility should be used only when the database behaves unpredictably, the help desk should be contacted prior to running the repair function.

Rep	Provider relations representative.
Repayment Receivables	Transaction established in the Cash Control System when a provider has received payment to which that provider was not entitled.
Replacement	Modification to a previous claim. HIPAA term for adjustment.
Report Item	Any unit of information or data appearing on an output report.
Required Field	Screen field that must be filled to display or update desired information. Sometimes designated by an asterisk (*).
Resolution	Step taken to correct an action that caused a claim to suspend from the system.
Resolutions	The area within the processing department responsible for edit and audit correction.
RID Number	Medicaid number assigned to the child by ICES.
RID Error Report	Report listing of invalid RID numbers. The RID number is a Medicaid number assigned to the child by ICES.
Route	Transfer of a claim to a certain area for special handling and review.
SE	EDS Systems Unit Engineer.
Secondary Referral Source	Additional source(s) of referral to the Early Intervention First Steps program
Service Provider	A person or public or private entity designated to provider Early Intervention First Steps program.
SPOE	System point of entry. A database program developed to track the children enrolled in the First Steps program.
SS Number	Social Security Number. The number used by the SSA throughout a wage earner's lifetime to identify eligible earnings under the Social Security Program. This account number consists of nine figures divided into three hyphenated sets, 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with SSCN.
Sort	Arranging query results by a selected variable such as date of service, provider number, amount paid, etc. Sort options may vary according to the type of query or the type of report.
Status	Condition of a claim at a given time, such as paid, pending, denied, and so forth.

Stop-Loss Insurance	<p>Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance reimbursements:</p> <p>Specific or individual-reimbursement - given for claims on any covered individual that exceed a predetermined deductible.</p> <p>Aggregate-reimbursement - given for total claims that exceed a predetermined level, such as 125 percent of the amount expected in an average year.</p>
Submission	The act of a provider sending billings to EDS for payment.
Suspended Transaction	A suspended transaction requires further action before it becomes a paid or denied transaction. Most commonly a transaction is suspended due to entry or compliance errors.
Suspense File	Electronic file where various transactions are placed that cannot be processed. Most commonly a transaction is placed in the suspense file due to entry or compliance errors.
Systems Analyst or Systems Engineer	<p>SA, SE. Responsible for performing the following activities:</p> <ul style="list-style-type: none"> • Detailed system and program design • System and program development • Maintenance and modification analysis and resolution • User needs analysis • User training support • Development of personal IHCP knowledge
TANF	Temporary Assistance for Needy Families. Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Taskbar	Microsoft standard terminology for the icons displayed across the bottom of a Windows application that provide access to active documents and applications.
Third Party	Any person or entity that is or may be liable to pay for health care and services rendered to an IHCP enrollee. Some examples of third parties include an individual or group plan health insurer, casualty insurer, a health maintenance organization (HMO), or an employer-administered ERISA plan.
Third Party Liability	TPL. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
Third-Party Resource	A resource available, other than from the department, to an eligible member for payment of medical bills. Includes, but is not limited to, health insurance, worker's compensation, liability, and so forth.

TIN	Tax identification number.
Toolbar or Tool Bar	Microsoft standard terminology for the icons displayed across the top of a Windows application representing specific features.
Uniform Resource Locator or Universal Resource Locator	URL. A resource identifier that describes its target by presenting a pathway for retrieving it. URL may include a protocol, a host computer, or how to find the target resource on that computer.
Unit of Service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
Universe	A logical grouping of like subject matter such as claims, provider, or member data.
User	Data processing system customer or client.
Void	Cancellation of a claim.
Web	The Web is a global system of servers that supports specially formatted files written in a code that links them together. Also known as the World Wide Web or the Internet.
Web interChange	A secure Web site offered by EDS that allows providers to inquire about IHCP claim information, submit electronic claims, verify eligibility, and maintain provider information.
Web site, Website, web site, or website	A group of World Wide Web pages usually containing hyperlinks to each other and made available online by an individual, company, educational institution, government, or organization.
Windows	A family of operating systems for personal computers. Windows provides a GUI, virtual memory management, multitasking, and support for many peripheral devices.
ZIP Code	Formerly known as Zone or Postal Zone. A five-digit address extension signifying a postal delivery area in the U.S. A four-digit addition has been added, but is not required for postal delivery.

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